NHS Standard Contract

Dementia Local Enhanced Service (LES)

Service Specification No.	
Service	Dementia LES
Commissioner Lead/s	Dr Anand Barmade, Strategic Clinical Executive Kate Tufnell, Head of Adult Mental Health Commissioning
Provider Lead	As signed
Period	1 April 2022 to 31 March 2023
Date of Review	End of contract period or as necessary

1. Population Needs

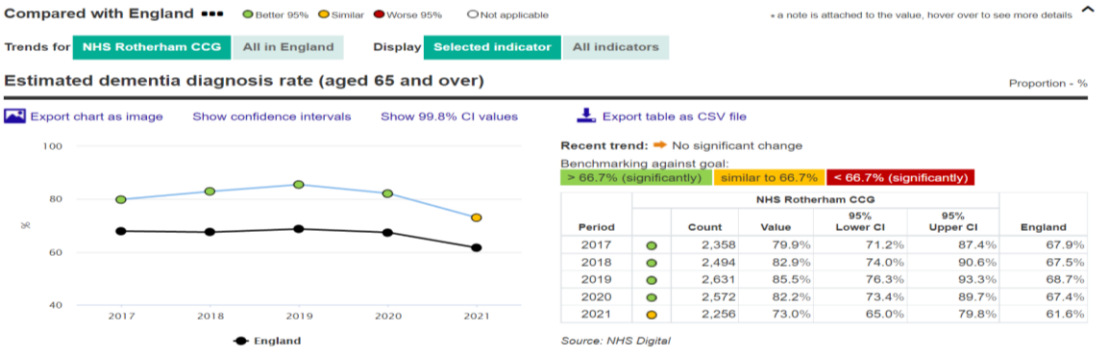
1.1 National context

It is estimated that there are approximately 700,000 people living with dementia in England and that this figure will steadily increase year on year. Getting an early diagnosis and good quality post-diagnostic support can make a significant, positive impact in people's lives. It enables them, their families and carers to plan for the future and can help to prevent crises. In addition to this there are an increasing number of treatments that can slow disease progression.

The Five Year Forward View and the Prime Minister's Challenge on Dementia 2020 provide guiding principles and an improvement framework for dementia care, focused on improving equity of access to timely diagnosis and improving the quality of post diagnostic support. As well as meeting the national diagnosis rate of 67%, there is the additional aim of increasing the number of people diagnosed with dementia within 6 weeks of a GP referral.

1.2 Local context

While Rotherham has always done well in terms of meeting the national diagnosis rate of 67%, the last two years has seen a reduction in local achievement. In March 2019, NHS England estimated that there were 3,078 people (aged 65 plus) living with dementia in Rotherham. Of these 2,631 people had a recorded diagnosis which equates to an estimated diagnosis rate of 85.5%. In 2021 the estimated number of people living with dementia had risen slightly to 3,128. Of these 2,276 people had a recorded diagnosis meaning the estimated diagnosis rate in 2021 had fallen to 73%.



Primary Care already carry out some dementia work in line with the Quality and Outcomes Framework (QOF).

- DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia
- DEM004. The % of patient diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months

This LES is an enhancement of the QOF work and has been designed to further improve the health outcomes of people living with dementia, by:

- Providing patients with a named professional responsible for coordinating their dementia care
- Carrying out an annual medications review
- Working in partnership with other professionals (further to obtaining appropriate consent permissions) to deliver holistic dementia care
- Supporting advance care planning that includes end of life care, ReSPECT and LPA documentation

This service should be provided in conjunction with the Shared Care Protocol (available on Rotherham CCG's intranet *Top Tips* page) and the dementia care check and follow-up interventions (Appendix One).

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

2.2 Local defined outcomes

- All patients with a diagnosis of dementia have an identified named coordinator of care (in line with NICE guidelines)
- All patients with a diagnosis of dementia receive an annual face to face review of their care plan
- Improved quality of post-diagnostic treatment and support
- Maintain a diagnosis rate of at least two-thirds (67%)

3. Scope

3.1 Aims

The main aims of the service are as follows:

- Referring patients for CT scans at the same time as making a referral to the RDaSH memory service
- Identifying a named coordinator of care for anyone who has a diagnosis of dementia
- Delivering an annual enhanced dementia care plan review. As and when appropriate, care planning should include recording preferences of care, discussions with regard to End of Life decisions and appointing of Lasting Power of Attorney and sharing these decisions
- Delivery of additional reviews (max. of two per patient) for patients with moderate to severe dementia

The provider will ensure that they promote this service to their patients opportunistically and by using promotional literatures. Services need to be accessible, appropriate and sensitive to the needs of all service users. The service should be inclusive and take into account race, gender, disability, sexual orientation, religion and/or age.

3.2 Objectives

Providers of the service will be required to:

- Ensure people with Dementia receive the same level of care among all GP practices in Rotherham
- Ensure each practice has a Lead Clinician for Dementia
- Enhance physical health care and health promotion advice for all people with Dementia
- Ensure carers of people living with dementia are supported and referred to the Carers Resilience Service, or other services as appropriate
- Follow-up all people with Dementia via delivery of, or referral to appropriate post diagnostic interventions

3.3 Service Description

Referral /follow up

- Refer patients for a CT scan at TRFT at the same time they are referred to the RDaSH memory service via choose and book
    - The Memory Service will pick up CT scan reports via ICE
    - The GP will pick up any incidental CT scan findings and action appropriately

- If a patient has had a CT scan within the preceding 12 months of being referred into the RDaSH memory service a new CT scan will not be necessary

As part of routine care (but not included in this LES) the following will be undertaken in primary care prior to referral

- Physical examination including pulse, blood pressure
- Dementia panel bloods (on ICE, includes RDaSH clinical referral requirements)
- 6-CIT and BADL

Note: if appropriate Carers can be referred to the Dementia Carers Resilience Service for support and information.

Annual Dementia Review in Primary Care:

- People living with dementia will receive an annual enhanced review

- Will be provided with a named coordinator of care
- Annual reviews will include the following elements (more details are available in **appendix One**)
    - Cognition, behaviour, risk and social circumstances
    - Physical health check
    - Care planning (developed and agreed with the patient and their carer)
    - Annual Bloods
    - Medication review

- The enhanced annual reviews will also include covering some of the components (as appropriate) not covered by QOF. It is noted that GPs will use their discretion in terms of when the best time to discuss these components are. Components include
    - advanced care planning to prepare for end of life,
    - Lasting Power of Attorney and ReSPECT discussions
    - Consideration of the carers needs/support requirements and where appropriate referral to the Dementia Carers Resilience Service

- All patients must have a named coordinator of care who will support partnership working with other agencies/resources to support the development of a holistic personalised care plan

People living with moderate to severe dementia may need more than one review every 12 months and this LES will cover up to 2 additional reviews where

- There are any concerns or risks identified in the annual review which need to be monitored on a more frequent basis than 12 monthly
- Any new physical health issues, interfering with dementia and dementia medication are present

For patients recently discharged from the RDaSH memory service, their first annual review should be held within six months of their discharge. (This will enable practices to stagger their patients' annual reviews, so the practices do not have to carry out lots of reviews in the same month. Transfer from the Memory Service will be managed, and information shared with relevant practices.)

Mild Cognitive Impairment pathway

For patients with a mild cognitive impairment (MCI) they will be reviewed annually and given advice to reduce their risk of dementia. Advice includes

- CVD: diabetes, blood pressure and smoking
- Nutrition: health diet and weight
- Physical activity and social contact

Annual reviews of MCI patients will continue until

- A non-dementia cause is established
- They are no longer appropriate
- The person has received a diagnosis of dementia

Patients with an MCI who have deteriorated to the point their GP thinks they now require a referral (or re-referral) into the RDaSH memory service, should be treated as a new referral and referred as above.

More information on the MCI pathway is available on Rotherham CCG's intranet Top Tips page

3.4 Target population and eligibility criteria
This service specification covers the delivery of service to those individuals for whom NHS Rotherham CCG is the responsible commissioner, as outlined in the NHS England guidance, "Who Pays? Determining responsibility for payments to providers" published August 2020 https://link.edgepilot.com/s/8ae998aa/niVl_NokcUy83EmoKreu-A?u=https://www.england.nhs.uk/publication/who-pays-determining-responsibility-for-nhs-payments-to-providers/

3.5 Exclusion criteria
This service specification does not cover

- People with early onset dementia
- People with comorbid neurodevelopmental disorders and dementia

3.6 Interdependencies with other services

- Rotherham Memory Clinic
- The Rotherham Foundation NHS Trust – particularly dementia specialists, geriatricians, and neurology
- Secondary Care Mental Health Services provided by RDaSH
- Community Learning Disability Team
- Other Community Health Care Teams
- Crossroad's Carers Resilience Service
- Alzheimer's Society, Dementia UK and other voluntary sector organisations
- Rotherham Social Care Services

3.7 Training Support

It is recommended that providers will

- Have a named Lead Clinician for Dementia who can support other professionals working within the practice as required
- Staff working with people living with dementia and undertaking the dementia reviews are required to:
    - understand what dementia is and how it might be experienced
    - understand relevant risks associated with dementia and issues that might require further investigation or onward referral into specialist services
    - feel confident to talk about health holistically and liaise with other professionals as required
    - have technical skills and expertise in relation to carrying out dementia reviews and understand issues in relation to mental capacity

It is recommended that lead clinicians undertake the online training resource for dementia such as this, which can be accessed via https://portal.e-lfh.org.uk/Component/Details/391247

4. Applicable Service Standards

4.1 Quality requirements
The service is expected to comply with the following relevant NICE guidance and any successor or updated guidance issued during the course of the LES:

- NICE NG 97 (2018) Dementia: assessment, management and support for people living with dementia and their carers
- NICE QS 1 (2010) Dementia: Support in Health and Social Care

All providers must meet CQC standards. Further details can be obtained from the CCG if needed.

The Provider shall:

- Maintain adequate records of the performance and results of the service provided.
- Maintain full records of all dementia enhanced reviews, including recording where patients have named coordinators of care and confirming that a personalised individual care plan is in place

4.2 Reporting Requirements

- Number of patients on Dementia register reviewed annually
- Number of additional Dementia reviews
- Number of patients with care co-ordinator
- Number of patients on MCI register
- Number of patients on MCI register reviewed annually
- Number of patients with completed care plans
- Number of patients with advanced care plans
- Number of Dementia medication reviews carried out

  - **Read codes**

- Dementia in Alzheimer's disease Eu00
- Dementia in Alzheimer's disease, atypical or mixed type Eu002
- Vascular dementia Eu01
- Unspecified dementia Eu02z
- Lewy body dementia Eu025
- Mild cognitive impairment Eu057

Additional Read Codes to be confirmed and added once reviewed

5. Prices and contract value

	Timings	Cost per patient
Annual enhanced review and allocation of named coordinator of care	20 Mins GP (£43.98) 10 mins nurse (£6.90)	£50.88
Follow up reviews	20 min nurse time	£13.80
MCI annual review	20 min nurse time	£13.80
Diagnostic CT scan	10 min GP time	£21.99

Payment will be made to practices for each complete annual review, MCI and follow-up review and diagnostic CT scan undertaken within each quarter.

Consequences for late submission of activity data:

- 1 – 7 days: 5% of payment
- 8 – 14 days: 10% of payment and payment won't be released until the next payment run
- 15 – 21 days: 50% of payment and payment won't be released until the next payment run
- Submissions received after 21 days (3 weeks) will receive no payment.

A reminder by email will be sent out at least one week prior to submission date. It is the responsibility of the practice to ensure that any changes to contact details for the Practice lead/ practice manager are notified to the GP Commissioning team.

In the event of unforeseen exceptional circumstances e.g. unplanned admission to hospital, there is scope for the CCG to process a payment without precedent. It is however a practice responsibility to put in place sufficient contingency arrangements to ensure activity is submitted by the date specified.

If the CCG makes a payment to a practice under the LES and:

- The practice was not entitled to receive all or part thereof, whether because it did not meet the entitlement conditions for the payment **or because the payment was calculated incorrectly** (including where a payment on account overestimates the amount that is to fall due);or

- the CCG was entitled to withhold all or part of the payment because of a breach of a condition attached to the payment, but is unable to do so because the money is already been paid,

then the CCG is entitled to repayment of all or part of the money paid.

Any suspicions of fraud will be referred to the CCG's Counter Fraud Specialist for further investigation. It is important to recognise that claiming for procedures that do not fall within the service specification may constitute fraud and will be referred to the CCGs Counter Fraud Specialist for further investigation.

- **Termination of Agreement**

This service forms part of the basket of enhanced services of the Rotherham Quality Contract and is therefore subject to the terms outlined in the Quality Contract.

Following the recent publication of the 'Investment and Evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan' the CCG acknowledges that further guidance may influence the future delivery of Local Enhanced Services.

All Local Enhanced Services will be subject to regular review in line with the development of Primary Care Networks (PCNs). Three months' notice will be given to Providers if services are to transfer to PCN delivery and/or payment.

The Practice and/or CCG may give three months written notice to terminate the service for reasons other than those outlined above.

An equalities impact assessment will be completed for this specification

Appendix One: Dementia care check and follow-up interventions

The following appendix provides more details of what should to be considered by practices when fulfilling the conditions of this LES. It is understood that clinicians may focus on specific areas in accordance with the individual presentation/needs of their patients and in doing so there may not be time to cover the entire list in one review. The lists below are given as a guide.

An enhanced annual health review

The annual review should take consideration of the following elements:

- Cognition, behaviour, risk and medication – involving:
    - Establishing patient consent to enquire about their memory and undertake review
    - Reviewing patients' medication in line with CCG Medicine Management guidelines / Medication discontinuation criteria
    - Drug compliance check - Any compliance issues should be discussed with patient and check if drug compliance aids required?
    - Changes in behaviours, such as: feeling agitated, verbal aggression, physical aggression, self-neglect, wandering, inappropriate sexual behaviour. Refer on if required
    - Carers - is any additional support required / referral required?

- Physical health check – involving
    - Blood pressure (sitting)
    - Pulse rate (sitting)
    - Bloods - FBC, haematinics, iron, TSH, bone profile, Lipids for vascular dementia
    - Smoking status (and give advice)
    - Alcohol intake (and give advice)
    - Annual flu vaccination
    - Encourage annual eye test
    - Nutritional status – any problems is SALT assessment required?
    - Mobility check/assessment
    - Risk of falling check – is onward referral required?
    - Are there any signs/concerns regarding depression, anxiety, sleeping, pain – is onward referral required/what additional interventions are required?

- Social Circumstances – involving
    - Identification of changes to social circumstances and if present consider referral to Social Care, Dementia Carer Resilience (includes financial advice), Link Worker /SPS
    - If patient has a carer (resident and/or GP registered in Rotherham) refer to dementia Carers Resilience service (CRS)
    - Activities: How does patient engage with family/friends/community? Do they have any support in place, is further support required?
    - Driving status: if driving give advice. Inform DVLA (and insurance company?) if required
    - Identify any safeguarding issues – self and others adults/children
    - Herbert protocol

- Care planning - involving
    - A joint annual review of the care plan OR commence a plan. Share copies with patient and carer/family

- Joint advance care planning and palliative – involving
    - Providing early and ongoing opportunities to discuss and/or review any advance statements and decisions made by the patient
    - Review whether patient is reaching end of life and if so, include on EoL pathway
    - Lasting Power of Attorney and ReSPECT discussions and signing off paperwork as required

- The first annual health review should be carried out within six months of a patient being discharged from the RDaSH memory service. Or for patients who have been diagnosed by a specialist GP, within six months of that diagnosis having been received
- Capacity reviews of PLWD in accordance with the Mental Capacity Act (MCA) should be carried out as necessary. Where a person is deemed not to have capacity use of an independent advocate must be considered.

Additional follow up reviews
The additional follow up reviews are intended for patients with moderate to severe dementia and are made up of the following elements

- Any concerns, risks, issues noted from annual enhanced review
- Any new physical health issues, interfering with dementia and dementia medications
- New appearance of features intrinsic to the disorder (e.g. wandering) and/or delusions or hallucinations due to dementia or as a result of caring behaviour (e.g. being dressed by a carer)
- Where there are concerns of patient deterioration a result of dementia a repeat of some or all of the areas identified under the annual review should be conducted, with re-referral to and/or advice sought from the memory service

Pre-diagnostic CT scan for anyone referred to the RDaSH memory service
Where further investigation is required for someone who has been assessed in primary care, there will be a requirement for a CT referral to be made (prior to referral to memory service). The following elements should be provided by practices

- Pre-diagnosis CT follow-up support
- Carers should be offered a referral to the Carers Resilience Service at this stage
- Any pre-diagnostic care needs should be identified and provided by practices

NICE guidelines recommend that people living with dementia should have a single named professional who is responsible for coordinating their care. The care coordinator should

- Arrange an initial assessment
- Provide information about services and how to access them
- Involve family and/or carers as appropriate in decision making
- Work in line with MCA principles when supporting people deemed not to have capacity
- Inform people of their rights to local advocacy service and if relevant IMCAs
- Jointly develop a care and support plan which
    - Is agreed by the patient and their family/carers
    - Included specific dates or timescales for review
    - Records progress towards identified objectives
    - Covers any comorbidity issues
    - It copied and given to the patient and their family/carers as appropriate.

The Dementia Shared Care Protocol and further information on Dementia and Mild Cognitive Impairment (MCI) are available on Rotherham CCG's intranet *Tops Tips* page